

CHAPTER 1

The unique nature of the healthcare environment

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LEARNING OBJECTIVES

After reading this chapter and completing the activities, you will be able to:

- discuss the historical foundations of healthcare in Australia and their impact on current healthcare provision
- describe the different frameworks for healthcare in Australia
- evaluate the political and policy drivers for healthcare provision in Australia
- critically examine the impact of socio-economics in relation to both accessing health services and the delivery of health services.

KEY TERMS

Frameworks for healthcare
Liberal individualist
Health policy
Person-centred care

Social determinants of health
Socio-economics
Social gradient

Social liberal
Universal healthcare

Introduction

When asked to describe the healthcare environment, many people will begin to describe a physical environment: a hospital, or a doctor's surgery or another of the many places that people can go to receive care.

However, this chapter will consider the healthcare environment as a combination of elements. These elements have shaped healthcare in Australia and continue to shape healthcare now and into the future. Healthcare is such a broad term that, aside from numerous definitions, we all have our own unique way of defining healthcare. Take a moment to consider a more personal definition of healthcare. Now think about people studying at university, and people in shopping centres on the weekend and a group of friends at the football: do they all have the same definition as everyone else? They probably don't.

Just like our understanding of health, people have many different definitions of healthcare. These many different beliefs, views, ideologies and definitions create a very unique healthcare environment in Australia.

In this chapter, the elements that shape the healthcare environment will be explored, including the historical foundations, political ideologies, political and policy drivers, the impact of socio-economics, and models and frameworks.

Liberal individualist

An ideology of individual and independent freedoms, particularly freedom of action, belief and expression. In health policy, liberal individualism shifts responsibility towards the individual and away from the government.

Health policy

The plans and actions put in place to achieve a specific health goal within a community or organisation. Health policy may be enacted by government or by private organisations.

Social liberal

Social liberal or social liberalism is a political ideology that aims to find balance between individual liberty and social justice.

Political ideologies

To truly understand the healthcare environment in Australia, it is important to gain some insight into the ideological differences that have long existed between the two most prominent political parties in this country: the Liberal Party—or, in some periods, the Liberal/National Coalition—and the Australian Labor Party. The Liberal Party and the Coalition partnership with the National Party have often taken a **liberal individualist** approach towards the provision of healthcare (Gray 2005). This approach favours minimal government intervention in **health policy**, and increased roles for private medicine and private health insurance. On the other hand, the Australian Labor Party has often taken a **social liberal** approach, suggesting that health should be publicly funded to ensure access and equity to all citizens. The result of these differences is a continual movement in Australia between public and private health insurance systems (Gray 2005).

How health is delivered or how a healthcare system is structured is individual to the needs of the community. There are a number of different healthcare systems; some are primarily government funded through tax systems, while others are primarily funded by the individual (pay-for-service). This continued movement between public and private approaches is unique to Australia, especially when compared to other OECD (Organization for Economic Co-operation and Development) countries (Gray 2005). This unique relationship between public and private sectors extends beyond the underlying politics of healthcare, reaching into everyday healthcare

practice and resulting in both positive and negative outcomes. Given the politics of healthcare and the link between healthcare consumer/professional interaction, communication, health outcomes and perceptions of healthcare quality (Asnani 2009; Clark 2003; Wanzer et al. 2004), a deeper understanding of the origins, inner workings and future directions of healthcare should result in improved interactions, improved health outcomes and improved quality perceptions.

Universal healthcare in Australia

Australia's current **universal healthcare** system is recent; however the history of its development and introduction is complex. Medicare, as we know it today, has only been in place since 1984, after being introduced by Labor Prime Minister Bob Hawke. The Hawke Government, although credited with the introduction of a long-term, stable universal healthcare system, cannot be credited with the inception of national universal healthcare in Australia. The movement towards national universal healthcare came almost 40 years before the introduction of Medicare.

In 1945, when the Chifley Labor Government came to power, a number of social reforms around health and pharmaceuticals began to take shape, as the government focused on shifting from a wartime economy (Swan 2009). Among the social reforms were changes to the constitution that gave the federal government more power over health matters. Prior to these changes in 1946, federal administration relating to health was limited to quarantine matters (Duckett & Wilcox 2011). This period was the beginning of a movement towards universal healthcare in Australia.

However, this movement towards universal healthcare was short lived. In 1949, the Menzies Liberal/Country Party Government came to power and modified the plans for national healthcare set in place by the Chifley Government. The Menzies Government opted for a health scheme that would provide free healthcare for those who couldn't afford it, and required the rest of the population to purchase private health insurance. This approach to healthcare required means testing, resulting in the very disadvantaged having access to free healthcare and the wealthy having private cover (Willis et al. 2009). However, means testing has a tendency to disadvantage those who fall between very disadvantaged and wealthy, as they are unable to access free healthcare but unable to afford private cover. This is exactly the scenario experienced in Australia during the 1960s, resulting from a two-tiered system of healthcare provision, leaving approximately 17 per cent of the population without any health cover at all (Willis et al. 2009).

The Menzies Government remained in power from 1949–1966 (NAA 2014). Sir Robert Menzies retired as prime minister in 1966, but the Liberal/Country Party coalition continued in power until 1972, when the Whitlam Labor Government came to power. By this stage, public dissatisfaction with the healthcare system was

Universal healthcare

All citizens are provided with required healthcare services and protection from financial burden when accessing healthcare services.

evident and the Whitlam Government seized the opportunity to introduce a new healthcare system similar to that proposed by the Chifley Government (Biggs 2004).

In July 1975, the Whitlam Government introduced Medibank (although credit for the Medibank concept should go to health economists John Deeble and Richard Scotton). However, the Whitlam Government was short lived, being dismissed by the Governor-General; as a result, Medibank failed to provide a long-term universal healthcare system. The Fraser Liberal/Country Party coalition came to power in November 1975 and quickly moved to modify the Medibank system. Medibank Mark II was introduced in 1976. Medibank Mark II attracted a 2.5 per cent levy on income, with the option of taking out private health cover to avoid the levy (Biggs 2004). In later years, the Fraser Government would enact a number of changes to the Medibank system, leaving it somewhat unrecognisable as a universal healthcare system.

It took until 1984 and the Hawke Labor Government for the introduction of a stable, long-term, universal healthcare system. Much like the original 1975 Medibank, the new system would undergo a name change along with changes to financing, including amendments to the *Health Insurance Act 1973*, the *National Health Act 1953* and the *Health Insurance Commission Act 1973* in an attempt to ensure its longevity.

The provision and arrangements for healthcare in any country present a number of challenges, one of the most noticeable being funding. Healthcare is expensive and needs to be financed somehow. Government-funded universal healthcare is usually funded by government income, such as taxes; however, as populations grow, the costs of healthcare also grow.

TABLE 1.1 Universal healthcare in Australia

1945: Chifley Labor Government introduces social and health reforms.
1946: Changes to the constitution to allow Commonwealth powers over healthcare.
1949: Menzies Liberal/Country Party Government provides means-tested healthcare: very disadvantaged receive government-funded healthcare; all others must have private health cover.
1975: Whitlam Labor Government introduces the Medibank medical insurance scheme.
1976: Fraser Liberal Coalition Government restructures Medibank, introduces Medibank Mark II.
1984: Hawke Labor Government introduces Medicare on 2 February 1984 as a long-term, universal healthcare system in Australia.

Continued change

The differing ideologies regarding the provision and financing of health services in Australia has led to a system of constant change. However, many of the basic principles first introduced by the Whitlam Government remain in place, creating what appears to be a stable, long-term, universal healthcare system. Although stability in healthcare provision appears to be a desired outcome, change is inevitable, as Australia's population profile has dramatically changed since the 1975 introduction of Medibank. In 1975, Australia's population was around 14 million people (ABS 2001), and in 2014 the estimated population was around 23.5 million people. The dramatic increase in numbers is not the only change in the population profile. Increases in life expectancy, changes in disease and illness—with decreases in infectious disease and increases in chronic disease—fluctuations in fertility rates, unemployment, home ownership, interest rates and inflation, have all had an impact on the transition of a population, leading to changing demands for healthcare. These changes are not just in consumption of healthcare, but in demands for its provision and funding.

The Australian health expenditure report (AIHW 2013) estimated health spending in Australia 2011–2012 at \$140.2 billion, compared to an estimated \$72.2 billion in 2002–2003 (AIHW 2004). In this short period of time, total health expenditure had almost doubled. The amount spent on health can increase for a number of reasons, such as increasing population demands, increasing costs of goods, new technologies or changes in the use of technology; even the social and economic structure of a population can influence how much is spent on health. Given the propensity of populations to change, it is easy to see why healthcare provision and consumption are so dynamic in nature. The ever-increasing cost of healthcare is quite often a political tug of war, with one side believing that, regardless of cost, universal healthcare should remain relatively unchanged, while the other believes that significant changes must be introduced to ensure the longevity of universal healthcare in Australia. Regardless of these opposing viewpoints, healthcare costs continue to rise and at some point someone will need to pay for the increases.

The dynamic nature of the healthcare environment also creates a continually evolving client–professional relationship that requires constant attention from all parties. Political influence and healthcare funding, pay-for-service arrangements, access to health information, social media and changing health needs all create a client–professional relationship that demands continual evolution. The healthcare environment is one of few sectors where macro and micro components, communication and influences combine to alter the interaction and communication between client and professional.

CASE ACTIVITY**1.1****HEALTHCARE PROGRESS**

Take a moment to think about health information access and consider the following scenario.

AUGUST 1980, SYDNEY, AUSTRALIA

Mr Rogerson is a 25-year-old male. He is experiencing a slight bulge in the middle of his abdominal region, approximately two centimetres above his belly button. He has noticed over the past weeks that the bulge is becoming larger, and it is quite painful. He decides he should probably see a doctor, and calls his GP. The receptionist for his GP explains that they are very busy, and won't have any appointments until early next month (September).

- When Mr Rogerson is told he will need to wait for an available appointment, what might his response be?
- What might Mr Rogerson take with him to prepare for his GP appointment, if anything?
- Is it likely that Mr Rogerson will make any treatment or diagnostic request at the appointment?
- If so, what might those requests be? If not, why do you think he wouldn't make any requests?
- Now change the date of the scenario to today, and consider the same questions again.

Since the introduction of universal healthcare in Australia there have been many changes associated with health and healthcare. The needs of populations have changed, and access to information about health and healthcare needs has changed dramatically, too. This access to information—although more evident in some sub-populations and specific age groups comfortable with technology and social media—has influenced the way that people access healthcare, communicate healthcare needs and consume healthcare. The introduction of the internet has enabled easy access to substantial amounts of health information (Hesse, Nelson, Kreps et al. 2005). The presence of this information, our understanding of health, what health means to us, and our ideologies regarding the provision of healthcare help to create our own individual model of healthcare. This information has also brought about a shift in the balance of power in health needs communication.

Since Australia's settlement, there has been a continued shift in communication of healthcare needs. From a macro perspective, government organisations traditionally communicated the needs to the people. However, communication has evolved, resulting in a move away from government and private organisations communicating what individuals and communities require, to individuals and

communities directing the communication about their specific healthcare needs. From a micro perspective, individual–health professional interactions have also evolved in favour of the individual, allowing for far greater communication of needs. The greater access to information, the greater the shift in both micro and macro communications.

Consider your own model of healthcare.

- What does health mean to you?
 - What does healthcare provision mean to you?
 - Consider how you established your understanding of health.
 - Where do your ideologies stem from?
 - Who influenced you?
 - What information influenced you?
 - Now think about how other people (clients or patients) might see health or the provision of healthcare.
 - As a health professional, it is likely that your ideologies will differ from those of your clients or patients. How might this impact on your interaction with them?
-

**Reflect
and apply**



Without really knowing it, we create our own healthcare model to suit our own individual ideologies; this conceptualisation can then be expanded to the community around us. What we create individually or as a community can be referred to as a model or framework for healthcare. Frameworks for healthcare generally reflect how health is conceptualised by individuals or communities (Taylor et al. 2008), and can be seen as the way in which healthcare is approached. However, it is unlikely that any two people will conceptualise the exact same framework, nor will any two communities. Like many aspects of health and healthcare, this is not a one-size-fits-all process.

Frameworks for healthcare

How health is conceptualised is reflected in the way that individuals, communities, government or private organisations approach healthcare.

So why are frameworks for healthcare necessary when governments and experts can tell us what healthcare needs to be delivered? Frameworks for healthcare actually guide health policy and the delivery of health services. We should really consider health frameworks as continually evolving concepts that can be shaped, adjusted or reinvented as the populations change and new evidence is introduced. As with different individual conceptualisations and different communities, the diversity of health practice areas, health-related sectors, and even the practitioners' ideologies, create the need for a large array of frameworks. A simple internet search

will demonstrate the diversity of healthcare frameworks. In this chapter we will focus on four primary frameworks:

- biomedical
- bio-psychosocial
- International Classification of Functioning (ICF)
- socio-ecological framework.

The biomedical model

The biomedical model is a model that people are most likely familiar with and, although they may not know it by name, it has most likely influenced health and healthcare beliefs of individuals and communities. The biomedical model has for a very long time provided the basis for healthcare, based on the premise that health is the absence of disease (Taylor et al. 2008; Wade & Halligan 2004). The biomedical model is entrenched in scientific understanding, suggesting that scientific processes can explain health and illness as the cause of disease; it is limited to biological causes, somewhat dismissing any causation related to psychological factors. As we learn more about health and wellbeing, it may seem easy to dismiss a model of care that only really considers the biological aspects of health or illness. However, the biomedical model still underpins a great deal of our medical understanding; it is the model we use to educate health professionals, and it still has a place in some health settings. The biomedical approach is somewhat limited regarding rehabilitation medicine, as the scientific nature of the model suggests that knowledge lies with the practitioner, creating barriers to effective therapeutic communication.

As mentioned earlier, the models or frameworks for healthcare are reflected in health policy and, to some extent, health spending. The biomedical model is quite clearly reflected in health spending. In 2008/2009 the proportion of public health spending to total recurrent government health spending was 2.8 per cent (AIHW 2011), and although this amount was an increase from previous years, it still remains a small proportion of total government recurrent spending, reflecting the focus of the biomedical model on physiological outcomes. However, the total amount spent on health is not necessarily a reflection of health outcomes, as the proportion of public health spending is more important regarding health outcomes (Baum 2011). The US provides a good example, as it has one of the highest health expenditures in the world while at the same time infant mortality remains higher than the average of the top ten OECD nations (Baum 2011). Although health spending would appear to be concerned with the macro level of health, the micro level is also impacted through resource allocation and utilisation. Resources in health can be physical, human or time, and their allocation and utilisation can influence client–professional interaction, health outcomes and perceptions of quality. A biomedical approach emphasising physiological outcomes may force resource allocation away from interventions or approaches that foster client-centred outcomes.

TABLE 1.2 Biomedical model of health and illness

Health and illness is physiological: the presence or absence of disease.

The aetiology of a disease is physiological and has a physiological or biological cause with the host body.

Balance of power in the relationship is significantly shifted towards the practitioner, who is the only expert in the equation.

Disease is curable and the systems are restorable as a result of medical intervention and cure.

Life experiences, psychological trauma and socio-economics are not considered contributing factors in the disease process.

Functioning of systems can be considered normal or abnormal; abnormal indicates some form of malfunctioning in the synchronisation of body systems.

Adapted from Taylor et al. 2008

The bio-psychosocial model

The bio-psychosocial model accommodates psychological and social contexts; however, it also encompasses a number of elements of the biomedical model. The bio-psychosocial model provides an example of the evolution of models or frameworks in response to changing needs and understanding about health and illness. The bio-psychosocial model evolved from the biomedical model in response to claims that the biomedical model was too narrow in its focus (Borrell-Carrio et al., 2004).

The bio-psychosocial model takes a holistic approach that considers the molecular and also the social context of disease (Borrell-Carrio et al. 2004; Taylor et al. 2008). However, given its origins are entrenched in the biomedical approach to health and illness, there is significant conflict regarding treatment and the balance of power between the health professional and the patient. Recognising the social context to health, barriers to therapeutic communication resulting from the biomedical component are slightly reduced under this model. These barriers can be further reduced when health practitioners acknowledge the existence of power relationships.

The impact of power relations on communication and interaction can be further reduced—or in some cases exacerbated—through individual–health professional terminology. For example, the term ‘patient’ traditionally demonstrates an imbalance in power, as the patient generally receives treatment or is acted upon. Although ‘patient’ may not carry the same meaning for everyone, it does carry an element of power shifting towards the health professional. On the other hand, the

terms ‘client’ or ‘consumer’ reset the balance of power, suggesting that the client or consumer is now acquiring services for their own personal needs; there is an element of control in the hands of the receiver. The use of different terminology proposes an underlying framework or belief from either party, which may result in either negative or positive communication outcomes.

TABLE 1.3 Bio-psychosocial model

Encompasses a worldview of health, and recognises the relationship between physical, psychological and social wellbeing.
Physical components of health, illness and function can be considered normal or abnormal; abnormal indicates some form of malfunctioning in the synchronisation of body systems.
Curative approach to physical systems.
Balance of power remains with the practitioner as the expert; the patient requires a curative approach to restore system functions.
Presenting symptoms approach: focus on the individual.
Recognises a relationship exists between physiological, psychological and social determinants of health; able to take a holistic approach to intervention.

Adapted from Taylor et al. 2008

International Classification of Functioning, Disability and Health (ICF)

The biomedical and the bio-psychosocial models provide a basis to drive health policy in a direction that considers more than just the physiological components of health and illness. However, as health and medical research continues to provide greater insight into the mechanisms of wellness it becomes evident that the previous models have limitations.

Health or wellness is far more than just physical and social contexts; it is individual and continually evolving via multiple inputs that include physical and social inputs, as well as environmental inputs, experiences, and much more. In 2001, the World Health Assembly (WHA), along with many governing bodies, adopted a new framework for healthcare: the International Classification of Functioning, Disability and Health (ICF) (Taylor et al. 2008). Although referred to as a new framework, it is an earlier framework redesigned to incorporate the changing needs of and understandings about health and wellness. The ICF actually

owes its origins to the International Classification of Impairments, Disabilities and Handicaps introduced in 1975 (Taylor et al. 2008).

The ICF moves beyond the biomedical and bio-psychosocial models of health: it recognises that health is for more than a physiological or social component, and recognises that wellness exists as a relationship between health and functioning. A key assumption within this framework is the continuum of health, illness and wellness: all three elements are dynamic (Taylor et al. 2008). Interestingly, this framework recognises that health and wellbeing are actually separate entities, and one does not necessarily suggest the presence of the other. The move towards this framework supports the very concept of rehabilitation medicine and it also suggests a directional change in health policy. The support from the World Health Organization (WHO) demonstrates a move away from a biomedical approach towards policy that addresses quality of life, engagement in activity and the reduction of the burden of disease. The ICF model enables therapeutic communication, as opposed to creating barriers, as the client now plays a significant role in the relationship and in their own treatment, thus leading to a need for higher levels of communication, as well as higher levels of awareness from the client. However, there is potential for a less positive outcome through use of this framework if the client group is firmly fixed in the biomedical approach. This emphasises the need for health professionals to be aware of individual health beliefs, allowing their models and approaches to evolve and adapt with changing client needs.

TABLE 1.4 International classification of functions as a framework for healthcare

Health is not static, but dynamic across the life span.
Recognises that health and wellness change in response to both physiological and environmental exposures.
Disability does not necessarily equal poor health; relationship between biological and social function suggesting quality of life and engagement in meaningful activity is significant to self-rated health and wellbeing.
The whole environment is associated with wellbeing, ranging from access to services and technology to the policies that impact on an individual or a community.
Participation in activities or daily life is vital to health and wellbeing; participation in meaningful activities or occupations is even more important.
The level of participation relates to physical, psychological and social wellbeing.
Recognises the relationship exists between physiological, psychological and social determinants of health; able to take a holistic approach to intervention.

Adapted from Taylor et al. 2008

The socio-ecological framework

The socio-ecological framework considers a population approach to health that, in its very nature, could be considered a true healthcare approach. The socio-ecological approach focuses on health at all levels of society (Taylor et al. 2008). Rather than just attending to the needs of the individual, a socio-ecological approach attends also to the needs of the whole community. It is a ‘public health’ approach: rather than treating illness, this approach is entrenched in promoting health and wellbeing. Although this appears to be the ideal framework for healthcare, it should be noted that in order for the socio-ecological framework to be applied successfully, elements from the biomedical model, the bio-psychosocial model and the ICF are required.

Reflect
and apply



- Consider the four models discussed and identify which components overlap.
- From the four models, select the elements that best suit your health ideologies and create your own model.
- Talk to someone older, such as a family member or friend, and build a framework for them. Consider the differences in your frameworks. How might insight into their framework for healthcare impact on your approaches to the delivery of health services?

TABLE 1.5 Socio-ecological framework for healthcare

Wellbeing is dependent on the interrelationship between person-to-person interaction, society and the environment.

Health, wellbeing and illness are complex beyond physiological matters; they are determined by life exposure, experience and beliefs.

Health and wellbeing go beyond the individual and encompass the community; expanding populations, interventions, policy and financing must recognise the relationships so that all components can reach their full potential.

The relationship between health and wellness goes beyond individual benefit; it can become a valuable resource for the community and the expanding population.

Health practitioners aim to prevent disease and illness, and to promote health and wellness.

Health is not the sole responsibility of health disciplines; preventative and promotive approaches cross disciplines and sectors, making health the responsibility of all.

Adapted from Taylor et al. 2008

Frameworks for healthcare extend well beyond the models presented in this chapter, and don't necessarily have to be published in textbooks or journal articles. They are conceptualisations that begin life belonging to an individual, based on the combination of exposures, experiences, education and personal beliefs for both the individual and the health professional. Each party's conceptualisation of health and healthcare has substantial influence on the balance of power in the healthcare relationship. For example, frameworks or approaches to healthcare—such as **person-centred**, family-centred or consumer-directed care—all view the individual as central to the provision of care, in essence creating a balanced partnership giving the individual sufficient power to direct their care. In order to reach a balance of power, both parties first need to communicate their healthcare beliefs and create an appropriate individualised framework that draws on multiple approaches. For a health professional, no single framework is likely to cater for all clients; instead, a constantly evolving framework based on primary care principles may be more appropriate.

Person-centred care

Care that is respectful of and responsive to an individual's preferences, needs and values, ensuring that those values guide all clinical decisions.

The driving force of health policy

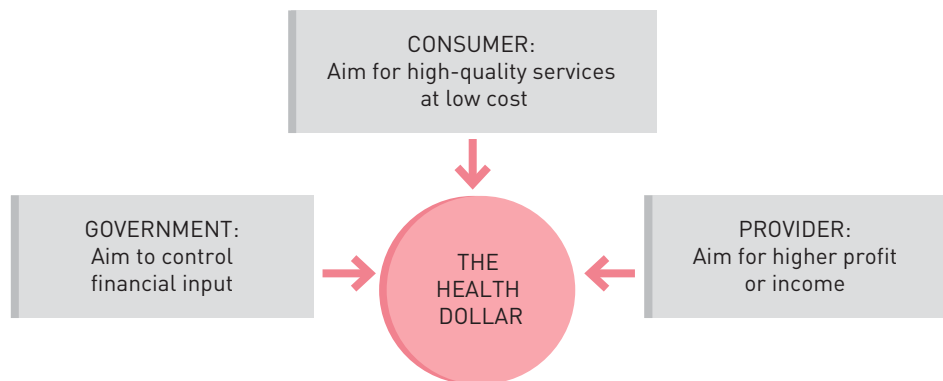
Healthcare models and frameworks provide a significant driving force in the development and implementation of health policy, and there are a number of associated stakeholders, ranging from politicians to private organisations. However, the politics of health policy is a double-edged sword: while one edge may nurture opportunities to advance health, the other edge may inadvertently (or knowingly) hinder any progress. Many undergraduate health professionals struggle to recognise the impact that politics might have on their own practice; however, the health professional is quite possibly the most affected—apart from the consumer—while also having the potential to be influential in health policy reform. It is not until entering the health workforce that graduates are faced with both sides of health policy: the elation when policy supports progress and the immense frustration when it hinders progress.

The predominant driver of health policy is money: health costs money. Going to the doctor, an allied health professional or any form of health service: at some point, someone has to be paid by someone else. Health is an industry driven by money. In Australia, it is driven by over \$140 billion a year (AIHW 2013). The fiscal nature of health creates interest from multiple stakeholders, some of whom are interested in the improvement of health and some of whom are interested in making money. As discussed earlier, the constant oscillation between public and private provision is unique to Australia, and balancing this oscillation remains a significant challenge to the universal healthcare system. This challenge is made even more difficult by multiple stakeholders with multiple interests.

Health is one of Australia's largest industries, estimated in 2005 at more than five times larger than defence (Gray 2005), and it continues to grow at a substantial

rate, offering multiple opportunities for great financial gain. AIHW figures suggest that health consumed approximately 9.5 per cent of the gross domestic product (GDP) in the 2008–2009 period (AIHW 2011). This figure is around 1 per cent more than the OECD average. The size and financial complexities of the health industry create conflict when trying to balance health policy. For example, providers want high profits and incomes while consumers seek access to quality services at affordable prices (Gray 2005), at the same time that governments want to keep tight control over health expenditure. This trio of players generates a conflict that requires continual nurturing to maintain an appropriate and acceptable balance. Governments, both state and federal, are responsible for a large proportion of health expenditure; therefore, a key policy driver from a government perspective is to minimise health inflation. This outcome is challenging, as healthcare costs have a tendency to increase faster than other costs because of new technologies and increasing utilisation. Also, private healthcare providers and health professionals tend to resist policy that may impact on, or place restraints on, their income. So providers and professionals are likely to oppose policy that aims to limit growth in expenditure unless they can find ways of ensuring that someone makes up the shortfall (Gray 2005). This ‘someone’ is usually the consumer, and the shortfall is generally made up through user charges (such as co-payments) or private health insurance premiums. This alters the relationship between professional and client, too, as the client still wants services and the professional still wants to provide services; however, a pay-for-service situation potentially creates a retail environment with the power shifting towards the consumer.

FIGURE 1.1: The health dollar



The conflict between the different stakeholders creates a number of problems with policy development and implementation. One problem is inconsistency within the policy itself, as well as inconsistency in implementation. The tension that exists between the stakeholders is often reflected in their interpretation and implementation of policy, as each stakeholder is likely to have a different view of

the policy outcome. This difference in interpretation and implementation often results in a reactive approach to health policy rather than a proactive approach to health policy. Unfortunately, the end result of this policy cycle is often failure to truly meet the needs of the consumer, at the same time as failing to meet the goals of the stakeholders. Reactive policy has a tendency to cost all of the stakeholders far more in the long run.

Policy drivers and flawed policy outcomes are not unique to Australia; many governments in other parts of the world experience the same problems, particularly with health policy. What is unique to Australia is significant government input, not just in raw funding but in the maintenance of power. Regardless of funding arrangements or service structure, Australian governments maintain control over healthcare. How they balance the funding and responsibilities depends greatly on the political party in power and their ideology, but it is clear that political parties in Australia recognise that health is held in high regard among voters, and that health policy has the potential to attract votes. That governments have maintained the balance of power over health despite mounting pressure from private interests is commendable; however, the power of health policy to attract votes only adds to the reactive nature of health policy in Australia.

Health, wealth and the consumer

Although the consumer is an extremely important stakeholder in health policy development and the delivery of health services, their input is often overlooked or given far less attention than it merits. The consumer provides significant insight into just what sort of healthcare should be provided. Historically, consumer input into health is one-sided, with health policy tending to favour the least disadvantaged of the population, regardless of the original intent of the policy. Unfortunately, opportunities for input from socially and economically disadvantaged consumers are less evident; however, the health professional has the potential to be an avenue of communication, allowing micro-level communication (client) to migrate to the macro level (government or policy maker), essentially playing the role of advocate.

One element that impacts health and wellbeing as well as access to health services or health information is **socio-economics**. In very simple terms, it appears that wealthy populations are healthier than poorer populations (Keleher & MacDougall 2011). Much has been written over the past two decades about health and social determinants (Begg et al. 2007; Keleher & Macdougall 2011; Marmot & Wilkinson 2006), in particular socio-economics and health. Research suggests that population groups experiencing low socio-economic status experience a far greater burden of disease (Begg et al. 2007) than other population groups. The most disadvantaged groups in Australia experience 31.7 per cent greater burden of disease than the most advantaged groups (Begg et al. 2007). Higher mortality rates have also been associated with lower socio-economic population groups across a

Socio-economics

The interaction between economics and social processes. Socio-economic status is a measure of an individual's economic and social position based on education, income and occupation.

number of causes of death (Draper et al. 2004), with the most disadvantaged people experiencing the highest mortality rates in Australia. Life expectancies have also been shown to differ between socio-economic populations, with the most disadvantaged groups of males having an expected longevity of almost four years less than the least disadvantaged group of males; for females, the difference is approximately two years. Graded relationships can also be found in a number of diseases, such as cardiovascular disease, diabetes and some cancers, with the most disadvantaged groups experiencing higher rates of disease.

Evidence to support the contribution of social and economic status to health continues to grow (Berg et al. 2007; Draper et al. 2004; Keleher & MacDougall 2011; Marmot & Wilkinson 2006). Medicare was built on the principles of universality, access, equity, efficiency and simplicity, the main objective being to break down the financial barriers to healthcare access for all Australians. Given the principles of Medicare, how is it possible that we are still able to identify disparities in health in relation to socio-economic status? Unfortunately there is no simple solution; however, what is known is that a number of social determinants can be linked to health and wellbeing, the most notable being social status, income and work (Fanany & Fanany 2012; Keleher & MacDougall 2011).

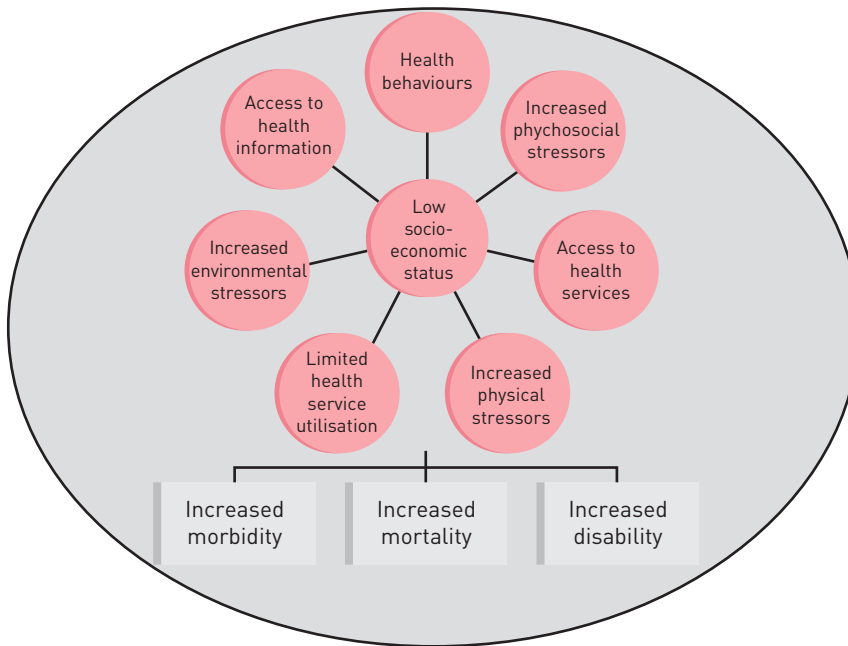
Social gradient

Social and economic circumstances affect health. Generally, the lower an individual's socio-economic status, the worse their health. This is a global trend, seen in low-, middle- and high-income nations.

The concept of socio-economic status is often described along a **social gradient**, with health improving or getting better as you move up the gradient (Fanany & Fanany 2012). We can further explore the concept of socio-economic status by including work as part of the health determinant. Given that much of our lives are spent working, it is evident that the type of work we do, the level of control we have over our work and the income it generates will also impact upon our health (Fanany & Fanany 2012). Socio-economics and the social gradient also create particular challenges for the health professional: the further down the social gradient the client is, the less likely that they have accessed significant education opportunities; this results in a mix of inputs used to create their own model of healthcare, ranging from cultural upbringing to social media and hearsay. This mix of inputs and conflict of healthcare attitudes creates a unique challenge in forming client–professional relationships, as well as in developing communication pathways to support positive health outcomes and healthcare experiences.

Declines in socio-economic status lead to decreases in health, regardless of the services provided. Financial access to services is only one step towards improving health in disadvantaged populations. A number of elements play a role in health and wellbeing, such as maintaining a healthy diet, drinking in moderation, avoiding addictions, maintaining physical fitness, making time to relax, and taking care of personal hygiene.

The relationship between financial stability and diet, drinking, addictions, physical fitness, relaxation and hygiene is easily recognised; however, consider how other social factors may impact on these elements. Many of the factors identified in the preceding discussion are very similar to the social determinants of health. Table 1.6 outlines the key social determinants of health.

FIGURE 1.2: Socio-economics and the health relationship**TABLE 1.6** Social determinants of health

The social gradient: Social and economic circumstances affect health, both individually and at a community level.

Stress: Lack of control can lead to stress, particularly in the workplace. Exposure to unfavourable social and psychological situations can lead to long-term stress.

Early life: Early development and education impact on health throughout life. The foundations for good health begin in early development.

Social exclusion: Social exclusion can be linked to depression; often linked to marginalised groups.

Work and unemployment: Work can contribute significantly to stress, increasing the risk of disease. Job security adds to wellbeing; unemployment or lack of job security increases psychological stress, further amplified by lack of financial security.

Social support: The presence of social support through friends and family contributes to good health and wellbeing; the absence of such support can negatively affect health and wellbeing.

(continued)

Social determinants of health

The economic and social conditions that contribute to or detract from health at an individual or community level.

TABLE 1.6 Social determinants of health (*continued*)

Transport: Healthy transport encourages better health through walking and cycling; this is also supported through reliable and affordable public transport. Apart from reducing pollution and road accidents, effective public transport also provides access to health services.
Gender: The impact of gender on health includes social roles, power and control in the community, family, environment and the workplace, as well as access to and engagement with health services.
Culture: Views and understanding of health and healthcare. Cultural and religious beliefs can impact on access to and utilisation of health services.

Healthcare in Australia is not a one-size-fits-all approach. Although many policies and programs exist in an attempt to improve the health of disadvantaged populations, positive health outcomes are limited. Several challenges that lay outside the realm of health policy limit the success of health programs; however, are all linked to socio-economics and social determinants of health. It is possible to provide substantial health services targeted at the needs of disadvantaged populations, although positive health outcomes also require that communities are aware of the services and have adequate access to them. Transport, education, working conditions, gender and culture all impact on how or if individuals or communities will access health services. These same social determinants also impact on the individual and the community’s healthcare framework, thus determining access and utilisation of services. Achieving positive health outcomes goes beyond just providing the care or service needed: it is far more complex than simply increasing the number of allied health professionals, midwives or GPs in an area. As much as this perspective is imperative for the policy-makers, it is just as imperative for the practising health professional in every role, from the frontline health worker to the service manager.

**Reflect
and apply**



As an individual you have developed your own framework for healthcare, and as a developing health professional it is likely that your framework will evolve as you progress through your undergraduate degree to become a practising health professional. The beliefs, ideologies and experiences that have gone into constructing your personal healthcare framework are important to you, and may differ substantially from someone else’s framework. Consider how knowing or not knowing about the construct of another person’s healthcare framework might impact on your approach to practice as:

- a frontline health professional
- a service manager
- a policy maker.

Conclusion

The current healthcare environment in Australia goes well beyond the physical location of health service delivery. Rather than just the physical, the healthcare environment is a conceptualisation of beliefs, ideologies, culture, history, interactions and evidence that continues to evolve and adapt to changing health needs and also in response to the changing ideologies of the Commonwealth Government. The evolution of the healthcare environment is reflected in the ways in which we deliver healthcare, and the way in which we view health and illness. It is complex and dynamic, and while there are many elements that individuals and communities share in the understanding of health and illness, there are also many elements that differ. These differences add to the complexities: the unique nature of the healthcare environment and the challenges in balancing the needs of the many stakeholders, which all play a role in maintaining the healthcare environment and allowing it to evolve. Biomedical approaches to health may have formed the basis of the current healthcare environment; however, evidence clearly suggests that there is far more to health and healthcare than this approach can accommodate. There are numerous social factors that influence health, healthcare and health policy that require careful examination and exploration when preparing for health services. Healthcare in Australia is not a one-size-fits-all scenario and, while no single stakeholder possesses all the answers, it is likely that a combination of ideologies from all players, combined with an ability to evolve and adapt, may provide an effective healthcare framework in the future. For the health professional, a deep understanding and engagement with all elements of the environment from policy making to client beliefs is likely to result in a modified framework capable of evolving to meet the needs of the health professional and the client, leading to improved client–professional communication, better health outcomes and improved resource utilisation.

SUMMARY POINTS

- Health and healthcare in Australia is an ever-evolving entity. The evolution of healthcare in Australia is not only dictated by the political ideologies but also directed by healthcare consumers. While healthcare stability is important, change is both inevitable and required to ensure population needs are continually met.
- The major political forces in Australian politics demonstrate substantially different ideologies towards the provision of healthcare in Australia; however, these differences act as a conduit for continual change, development and improvement of healthcare in Australia.
- The complexities of healthcare provision are further exacerbated by the complexities of the populations requiring healthcare. Individuals and communities differ in their

healthcare needs and beliefs—or how they conceptualise health and healthcare. Frameworks for healthcare help to communicate what health means from an individual perspective as well as from a population or community perspective. A deeper understanding of the meaning of health supports the provision of meaningful health services.

- Healthcare and health policy in Australia has multiple stakeholders with multiple interests; some stakeholders are interested in profit, some are interested in services and some are interested in reducing expenditure and input. Consumers, providers and government are all stakeholders in health policy.
- Healthcare communication is a complex entity that goes beyond the micro level of client–professional interaction. The macro level is concerned with the broader communication of health needs. Consumers communicate their needs at a micro level through healthcare providers, and at a macro level via the polling booth. Providers communicate their needs through advocating policy, or by resisting policy changes that impact upon them at a personal or organisational level. Provider interactions can be both micro and macro: micro when communicating individual needs, and macro when communicating client or community needs.
- Political drivers are not the only element shaping healthcare. Health, healthcare and health policy are all influenced by a multitude of social factors. Balancing the differing needs of individuals and communities adds an extra layer of complexity.

Critical thinking questions



- 1 The future of Medicare is constantly in the political spotlight. What are your views on current debates? Do you have a secret solution? How might your solution impact on vulnerable and affluent people in our society?
- 2 It is often said that Australians possess the best healthcare system in the world. Why might this attitude prevail? Reflect on your knowledge of healthcare in other countries and make the comparisons.

WEBLINKS



<http://www.humanservices.gov.au/>

Australian Government Department of Human Resources.

http://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/Publications_Archive/archive/medicare Medicare Background: Parliament of Australia.

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